United States Department of Labor
Employees' Compensation Appeals Board

K.B., Appellant	)	
and	)	**Docket No. 16-1146**
	)	**Issued: March 21, 2017**
U.S. POSTAL SERVICE, POST OFFICE, Tuckerton, NJ, Employer	)	

Appearances:
Thomas R. Uliase, Esq., for the appellant[1]
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
PATRICIA H. FITZGERALD, Deputy Chief Judge
COLLEEN DUFFY KIKO, Judge

JURISDICTION

On May 11, 2016 appellant, through counsel, filed a timely appeal from a November 13, 2015 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[2] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this case.

ISSUES

The issues are: (1) whether OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits, effective February 13, 2015, because he no longer

[1] In all cases in which a representative has been authorized in a matter before the Board, no claim for a fee for legal or other service performed on appeal before the Board is valid unless approved by the Board. 20 C.F.R. § 501.9(e). No contract for a stipulated fee or on a contingent fee basis will be approved by the Board. *Id.* An attorney or representative's collection of a fee without the Board's approval may constitute a misdemeanor, subject to fine or imprisonment for up to one year or both. *Id.; see also* 18 U.S.C. § 292. Demands for payment of fees to a representative, prior to approval by the Board, may be reported to appropriate authorities for investigation.

[2] 5 U.S.C. § 8101 *et seq.*

had residuals of the accepted right elbow strain and right biceps tendon rupture; and (2) whether appellant established that he had any continuing employment-related disability or condition after February 13, 2015 due to the accepted conditions.

On appeal counsel asserts that the opinion of Dr. Ian Fries, a Board-certified orthopedic surgeon, cannot carry the weight of the medical evidence and, therefore, OWCP did not meet its burden of proof to terminate appellant's compensation benefits.

FACTUAL HISTORY

On March 11, 2011 appellant, then a 32-year-old part-time flexible clerk, filed a traumatic injury claim (Form CA-1) alleging that on February 15, 2011 he injured his right elbow and forearm when placing parcels in a hamper. He had stopped work on March 10, 2011. Appellant returned to modified duty on June 6, 2011.

OWCP denied appellant's claim by decision dated April 29, 2011. Appellant requested a hearing. In an October 6, 2011 decision, the hearing representative reversed the April 29, 2011 decision and accepted right elbow sprain and right biceps tendon rupture. Appellant stopped work on November 12, 2011 and did not return. OWCP paid appellant compensation and placed him on the periodic compensation rolls.

On December 19, 2011 Dr. Barry S. Gleimer, a Board-certified osteopath specializing in orthopedic surgery, surgically repaired the biceps tendon rupture. On February 1, 2012 the physician noted that appellant was improving and would begin therapy.

On March 7, 2012 appellant came under the care of Dr. Mohsen Kalliny, Board-certified in anesthesiology and pain medicine and an associate of Dr. Gleimer. Dr. Kalliny reported that approximately 10 days prior appellant had the onset of new burning, stabbing, and aching pain in the region around the surgical incision into his right arm. He advised that Dr. Gleimer had called that day for an immediate consultation because he was concerned regarding complex regional pain syndrome (CRPS). Dr. Kalliny diagnosed status post biceps tendon repair, questionable ulnar neuropathy, and CRPS of the right upper extremity. He recommended stellate ganglion blocks.

In March 2012, OWCP referred appellant to Dr. Kenneth P. Heist, a Board-certified orthopedic surgeon, for a second-opinion evaluation. In an April 3, 2012 report, following his review of the statement of accepted facts and medical record, he noted examination findings and diagnosed status post right distal biceps tendon repair. Dr. Heist reported that appellant continued to have marked restriction of shoulder and elbow motion which should resolve within six months following surgery, allowing appellant to return to full unrestricted duty.

In reports dated April 4, May 16, and July 25, 2012, Dr. Gleimer diagnosed contracture of the right elbow and reflex sympathetic dystrophy (RSD) of the right upper extremity which, he opined, was caused by the February 15, 2011 employment injury.

Dr. Heist reexamined appellant on July 12, 2012. He reviewed more recent medical reports from Dr. Gleimer and Dr. Kalliny and noted that appellant had improvement in right arm range of motion, but still some restriction in right elbow flexion. Dr. Heist reiterated his

diagnosis and opined that appellant was capable of returning to full-duty employment without restrictions. On September 4, 2012 he advised that appellant could perform his full postal duties even with the slight restriction in elbow flexion. Dr. Heist further indicated that his examination did not reveal any signs of RSD.

In reports dated September 18 and November 15, 2012, Dr. Kalliny reiterated his findings and conclusions.

OWCP determined that a conflict in medical evidence had been created between the opinions of Dr. Kalliny and Dr. Heist regarding appellant's diagnosis and whether he continued to be disabled. On April 22, 2013 appellant was referred to Dr. Ian B. Fries, a Board-certified orthopedic surgeon, for an impartial evaluation.[3]

A May 15, 2013 upper extremity electromyogram and nerve conduction velocity (EMG/NCV) study was read as abnormal with evidence consistent with bilateral carpal tunnel syndrome, left slightly worse than right. There was no evidence of entrapment at the elbow (cubital tunnel syndrome), and no evidence of right or left cervical radiculopathy or brachial plexopathy.

In a May 28, 2013 report, Dr. Fries noted the history of February 15, 2011 injury and appellant's current complaints of an overall sunburn sensation in the right forearm with increased sensitivity, and an area of numbness around the surgical incision. Appellant reported a sharp stabbing ache over the olecranon that extended down the ulnar shaft, increased palmar sweating on the right, knuckle swelling on the right, and blotchy redness of his right dorsal hand. He also described popping and pain with right forearm pronation, and loss of sensation in the middle, ring, and little fingers, and indicated that he would occasionally lose control and drop things. Dr. Fries described his review of the statement of accepted facts and medical record. Upper extremity examination demonstrated a well-healed scar over the proximal right forearm from the biceps repair. Right arm, elbow, and wrist range of motion was diminished. Palmar flexion was 60 degrees bilaterally. Carpal compression test on the left produced tingling in the thumb and fingers.

Appellant was able to don a pair of cloth gloves without difficulty, and reported less irritation to touch over the dorsal right hand with the glove on. He removed both gloves one finger at a time, without difficulty. Finkelstein test was negative bilaterally, although appellant complained that wrist motion produced a burning sensation over his left distal ulna. Finger motion was full, with no flexion or extension contractures. Appellant reported pain and allodynia widely over the right forearm from elbow to wrist, and more mildly over the center of his dorsal right hand, but not the fingers.

[3] The record indicates that Dr. Fries was the first physician in the Medical Management Application roster. Therefore, no physicians were bypassed prior to his selection. It is further noted that April 2012 and April 2013 appellant's monetary compensation was suspended because he failed to submit required CA-1032 forms. He submitted the forms in May 2012 and May 2013, and his compensation was restored retroactively on May 8 and June 3, 2013 respectively.

Dr. Fries indicated that expressed sensitivity precluded fully examining the forearm and elbow, but bony landmarks, specifically the olecranon, and medial and lateral epicondyles, were not painful. Appellant could not tolerate examination of the distal biceps, cubital fossa, or proximal radius and barely allowed light touch of the volar forearm. Biceps reflexes were hypotonic bilaterally. Hoffmann sign was negative bilaterally. Appellant could not tolerate pressure against the dorsal wrist to test right wrist dorsiflexion, which was normal on the left. Grip strength was variable but good bilaterally. Elbow flexion appeared strong bilaterally. Internal and external shoulder rotation and shoulder abduction, both in anatomic position and 45 degrees of adduction, were intact. Scapular elevation was intact bilaterally. Two-point testing of sensory discrimination on the right hand was 5/5 over all fingers.

Appellant accomplished four coin pickups without difficulty bilaterally, with vision and blinded. He was able to distinguish the time quickly with the left hand, somewhat slower on the right. Due to sensitivity, the physician could not perform an Allen test, but noted good capillary filling of all fingers bilaterally, and palpable radial pulses bilaterally. Dorsal and palmar temperatures were equal bilaterally. Grip strength was diminished on the right. Upper arm, forearm, wrist, and hand circumferences were equal bilaterally.

Dr. Fries reviewed the EMG/NCV study. He diagnosed right biceps tendon rupture, postsurgical repair, right elbow strain, right forearm pain, bilateral carpal tunnel syndrome, and ineffective and unmonitored chronic narcotic maintenance. Dr. Fries noted the accepted conditions and advised that the biceps tendon rupture was successfully repaired and that an elbow strain was expected to resolve over several weeks, with no objective findings of this diagnosis on his examination. Appellant had excellent right arm dexterity as he could easily write, remove and replace his polo shirt, and offer his right hand for a handshake. There were no objective changes such as discolorations, nail changes, skin abnormalities, or joint contractures, and no measurable swelling or edema. Both hands had equal surface temperature measurements. Dr. Fries found that the only joint with decreased motion was the right elbow which lacked full extension which was a typical finding following a distal biceps repair. He opined that appellant did not meet accepted criteria for CRPS, also called RSD, noting that his subjective forearm pain and allodynia (pain in response to nonnoxious stimulation) were not in an expected distribution for CRPS, and not one he had ever encountered in his practice. Dr. Fries concluded that appellant's symptoms were insufficient to confirm this diagnosis.

Dr. Fries advised that examination findings were insufficient to consider appellant fully disabled, noting that he demonstrated good dexterity, including the ability to handle light objects with his right hand, and that he had an entirely normal left hand. While elbow examination showed a mild loss of full extension, appellant had no pain or crepitation on range of motion, and the biceps repair was functioning well. Dr. Fries concluded that appellant's minor elbow findings were insufficient to preclude employment, noting that few activities required a fully extended elbow, and that he even lacked 10 degrees of extension of the unaffected left elbow. He further noted that the EMG/NCV study did not confirm pathology explaining appellant's claimed numbness involving his right fingers. Dr. Fries indicated that appellant's claimed degrees of pain suggested little benefit from continued addictive analgesics which were not being appropriately managed, noting that random testing, pill counting, prescription checking, and a pain contract were not documented. He maintained that narcotics, administered without

objective evidence of benefit, exposed a patient to significant risks of addiction, and had been shown to actually increase the pain experienced.

In answer to specific OWCP questions, Dr. Fries advised that, based solely on subjective complaints, use of appellant's right-dominant arm should be restricted to five pounds, which was based on his claimed intolerance, and not measurable findings, and that he had unlimited use of his uninvolved left arm. He advised that appellant did not have current disability due to the February 15, 2011 work injury or to any other unrelated condition other than a claim of forearm pain. Dr. Fries advised that appellant needed no further treatment for the accepted right elbow strain and right biceps tendon rupture which had healed long ago. He did not recommend a work capacity evaluation or work hardening, noted that appellant did not have sufficient objective findings to justify a spinal cord stimulator, and indicated that there were no objective findings that appellant had aggravation of a prior existing condition due to the work injury. Dr. Fries noted that the EMG/NCV study confirmed bilateral carpal tunnel syndromes, but surmised that this condition was unrelated to appellant's right elbow injury, and that he had only mild subjective findings on the left, consistent with the test results. He concluded that appellant was fully employable with restricted use of his right arm, based solely upon his claimed impairment. In an attached work capacity evaluation (Form 5c) Dr. Fries advised that appellant could not perform his regular job, noting a five-pound restriction on pushing, pulling, and lifting with the right upper extremity.

On May 22, 2013 Dr. Kalliny reviewed the EMG/NCV study findings, noting that appellant had positive Tinel's signs over both median nerves. He observed that appellant used his right arm with greater fluidity and normalcy than previously, even though he maintained that his symptomatology would vary in degree and severity, and that appellant did not feel it was fully resolved. Dr. Kalliny indicated that a right arm temperature differential was not dramatic at the time of his examination, and a color differential was not present. He diagnosed clinically, decreased, and persistent sympathetic pain syndrome of the right upper extremity and bilateral carpal tunnel syndrome, left greater than right. Dr. Kalliny recommended a psychological evaluation for chronic pain. He concluded that appellant could work part-time, light duty.

The employing establishment forwarded a July 25, 2013 investigation report by its Office of Inspector General (OIG). This indicated that appellant was observed from March 4 through May 29, 2013. Surveillance disclosed that he could drive and open and close a vehicle door using his right arm and hand. Appellant repeatedly used his right arm and hand to smoke and manipulate a pack of cigarettes. He bent his right elbow while holding tissue for a period of time, played slot machines, was able to fully extend his right arm, and reached above his head. Appellant also twisted in and out of his vehicle with no signs of difficulty, placed items in his vehicle using his right hand and arm, and lifted objects simultaneously while using his right hand, all without showing signs of pain or discomfort. The report also included descriptions of interviews regarding the circumstances of the claimed injury, a handwritten statement by a coworker, photographs, and medical evidence. Digital video discs (DVDs) were provided.

On August 21, 2013 Dr. Gleimer noted that appellant continued to have right arm dysesthesias. He advised that appellant's CRPS, which was improved, was related to the work injury, and that, while appellant could lift five pounds of weight, he could not perform repetitive activities. Dr. Gleimer opined that use of appellant's right arm on a regular basis, such as at

work, would be of benefit. He concluded that appellant's biceps tendon repair had healed except for some crepitus consistent with suture irritation and some limited motion, and that he still had neurogenic pain affecting his right upper extremity.

In treatment notes dated July 24, 2013 to July 24, 2014, Dr. Kalliny noted that appellant continued to have complaints of severe chronic right upper extremity pain, numbness, and tingling with temperature changes and sweating. He diagnosed stable right biceps tendon repair, right ulnar neuropathy, and CRPS of the right upper extremity.

OWCP again referred appellant to Dr. Fries. In a notification letter dated August 4, 2014, it informed appellant that it had forwarded surveillance DVDs to Dr. Fries.

In an August 21, 2014 report, Dr. Fries advised that he did not see a necessity to reexamine appellant. He reviewed a June 10, 2014 statement of accepted facts and medical evidence submitted after his May 28, 2013 report. Dr. Fries reviewed the OIG report and surveillance video which showed appellant performing activities with his right arm such as opening car doors, smoking, carrying, eating an ice cream cone, and playing a slot machine. He opined that the videos showed no impairment of appellant's right arm. Dr. Fries related that his review of the medical records and surveillance video supported his previous opinion regarding appellant's condition and were consistent with his examination findings. He noted that, while EMG testing showed carpal tunnel syndrome, this was not employment related. Dr. Fries advised that, while he provided right arm restrictions following his May 2013 examination, after his review of the surveillance video, appellant could perform full-time full duty. He noted his review of a stamp supply clerk position and advised that appellant could perform this position.

In July 2014, the employing establishment offered appellant a position of modified sales, service position with sedentary duties. Appellant refused the position on July 25, 2014, stating that, due to his restrictions, he could not perform the job duties.

In reports dated August 13 and October 8, 2014, Dr. Kalliny reiterated his findings and conclusions.

On December 19, 2014 OWCP proposed to terminate appellant's wage-loss and medical benefits. It noted that it had forwarded the OIG investigative report and surveillance DVDs to Dr. Fries. OWCP concluded that Dr. Fries' impartial medical opinion constituted the weight of the medical evidence.

In correspondence dated January 17, 2015, appellant disagreed with the proposed termination. He maintained that none of the activities listed by Dr. Fries in his review of the surveillance video exceeded the five-pound restriction appellant had been given by Dr. Kalliny and that Dr. Fries' opinion was insufficient to carry the weight of the medical evidence. Appellant noted that the position reviewed by Dr. Fries, a stamp supply clerk, was not appellant's regular position of sales and service associate.[4]

[4] Appellant also pointed out typographical errors in the December 19, 2014 notice.

In reports dated December 4, 2014 and January 28, 2015, Dr. Kalliny noted appellant's report of fluctuating right upper extremity pain, and that carrying his newborn caused difficulty the rest of the day and with sleeping at night. Right upper extremity examination demonstrated normal range of motion of all joints with noticeable color and temperature changes. Dr. Kalliny reiterated his diagnoses.

In a February 13, 2015 decision, OWCP terminated appellant's wage-loss compensation and medical benefits. It found that the weight of the medical evidence rested with the opinion of Dr. Fries who provided an impartial evaluation and concluded that the accepted right elbow sprain and right biceps tendon rupture had resolved with no residuals.

Appellant, through counsel, timely requested a hearing. Counsel also requested a complete copy of the record. On August 26, 2015 he requested that the request be converted to a review of the written record.

In reports dated March 11 to October 30, 2015, Dr. Kalliny reiterated that appellant had CRPS due to the work injury. He noted that appellant symptoms varied, but that he continued to have right upper extremity pain, color variations, and intermittent swelling. On September 3, 2015 Dr. Kalliny advised that appellant could return to work with no repetitive use of the right arm, that he was to have 30-minute breaks every 2 hours, and was not to lift more than 10 to 15 pounds. On October 2, 2015 he noted that appellant had returned to work.

In a November 13, 2015 decision, an OWCP hearing representative affirmed the February 13, 2015 OWCP decision. She found that the weight of the medical evidence rested with Dr. Fries' opinion that appellant had no residuals of the accepted conditions. The hearing representative noted that, in his August 21, 2014 supplemental report, Dr. Fries reviewed the OIG report and video surveillance.

LEGAL PRECEDENT -- ISSUE 1

Once OWCP accepts a claim and pays compensation, it has the burden of justifying modification or termination of an employee's benefits. It may not terminate compensation without establishing that the disability ceased or that it was no longer related to the employment.[5] OWCP's burden of proof in terminating compensation includes the necessity of furnishing rationalized medical opinion evidence based on a proper factual and medical background.[6]

Section 8123(a) of FECA provides that, if there is disagreement between the physician making the examination for the United States and the physician of the employee, the Secretary shall appoint a third physician who shall make an examination.[7] The implementing regulations provides that, if a conflict exists between the medical opinion of the employee's physician and the medical opinion of either a second opinion physician or an OWCP medical adviser, OWCP shall appoint a third physician to make an examination. This is called a referee examination, and

[5] *Jaja K. Asaramo*, 55 ECAB 200 (2004).

[6] *Id.*

[7] 5 U.S.C. § 8123(a); *see Y.A.*, 59 ECAB 701 (2008).

OWCP will select a physician who is qualified in the appropriate specialty and who has no prior connection with the case.[8] When there exist opposing medical reports of virtually equal weight and rationale and the case is referred to an impartial medical specialist for the purpose of resolving the conflict, the opinion of such specialist, if sufficiently well rationalized and based upon a proper factual background, must be given special weight.[9]

ANALYSIS -- ISSUE 1

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits on February 13, 2015. The accepted conditions are right elbow strain and right biceps tendon rupture. Dr. Gleimer repaired the biceps tendon rupture on December 19, 2011. Appellant last worked on November 11, 2011. He was placed on the periodic compensation rolls.

OWCP determined that a conflict in medical evidence was created between the opinions of Dr. Kalliny, an attending pain management specialist, and Dr. Heist, an OWCP referral orthopedist, regarding appellant's work-related diagnoses and whether he had any continuing disability causally related to the February 15, 2011 work injury. It then properly referred appellant to Dr. Fries, a Board-certified orthopedic surgeon, for an impartial evaluation.

In a comprehensive May 28, 2013 report, Dr. Fries reviewed the history of injury, the medical record, and appellant's current complaints. He reported extensive examination observations and diagnosed right biceps tendon rupture, postsurgical repair, right elbow strain, right forearm pain, bilateral carpal tunnel syndrome, and ineffective and unmonitored chronic narcotic maintenance. Dr. Fries advised that the accepted biceps tendon rupture was successfully repaired and that there were no current objective findings of the accepted right elbow sprain. Appellant demonstrated excellent right arm dexterity as he could easily write, remove and replace his polo shirt, and offered his right hand for a handshake. He advised that there were no objective changes such skin abnormalities or joint contractures, and no measurable swelling or edema. Dr. Fries found that, while appellant had mild decreased motion of right elbow, this was typical after a distal biceps repair. He opined that appellant's symptoms were insufficient to confirm a CRPS diagnosis. Dr. Fries advised that appellant's findings were insufficient to consider him fully disabled, noting that his minor elbow findings did not preclude employment as few activities required a fully extended elbow. He indicated that, based on appellant's claimed intolerance and not on measurable findings, use of his right arm should be restricted to five pounds. Dr. Fries advised that appellant had no disability due to the February 15, 2011 work injury or to any other unrelated condition other than a claim of forearm pain. He concluded that appellant needed no further treatment for the accepted right elbow strain and right biceps tendon rupture, which had healed long ago. Dr. Fries noted that, while EMG/NCV study confirmed bilateral carpal tunnel syndrome, this condition was unrelated to appellant's right elbow injury. He concluded that appellant was fully employable with restricted use of his right arm, based solely upon his claimed impairment, and that, while he could not perform his regular job, he could work modified duty with a five-pound restriction on pushing, pulling, and lifting.

[8] 20 C.F.R. § 10.321.

[9] *V.G.*, 59 ECAB 635 (2008).

Dr. Fries reported on August 21, 2014 that he reviewed a June 10, 2014 statement of accepted facts, medical evidence submitted subsequent to his May 28, 2013 report, and the OIG investigative report and the surveillance videos. He opined that the videos showed no impairment of appellant's right arm. Dr. Fries related that his review of the medical records and surveillance videos supported his previous opinion regarding appellant's condition and were consistent with his examination findings. He advised that the diagnosed carpal tunnel syndrome was not work related and that, while he previously provided right arm restrictions, after his review of the videos, appellant could work full-time full duty.

The Board finds that Dr. Fries' opinion, in which he clearly advised that any residuals of appellant's accepted conditions had resolved and that he could return to full-time full duty, is entitled to the special weight accorded an impartial examiner and constitutes the weight of the medical evidence.[10]

The medical evidence appellant submitted prior to the termination on February 13, 2015 is insufficient to overcome the weight accorded to Dr. Fries as an impartial medical specialist regarding whether appellant had residuals of his accepted conditions.

Dr. Gleimer was consistent in his opinion that appellant's CRPS was related to the February 15, 2011 work injury, but CRPS has not been accepted as employment related. He failed to sufficiently explain why appellant continued to be totally disabled. In fact, Dr. Gleimer opined that use of the right arm on a regular basis, such as at work, would be beneficial to appellant.[11]

Dr. Kalliny furnished March 7, 2012 to January 28, 2015 reports. He was consistent in his opinion that appellant had CRPS resulting from the February 15, 2011 employment injury. Dr. Kalliny also diagnosed bilateral carpal tunnel syndrome. Neither CRPS nor carpal tunnel syndrome, however, has been accepted as employment related. Furthermore, Dr. Kalliny was on one side of the conflict resolved by Dr. Fries. The Board has long held that reports from a physician who was on one side of a medical conflict that an impartial specialist resolved, are generally insufficient to overcome the weight accorded to the report of the impartial medical examiner, or to create a new conflict.[12]

The Board therefore concludes that Dr. Fries' opinion that appellant had recovered from the employment injury is entitled to the special weight accorded an impartial medical examiner and the additional medical evidence submitted is insufficient to overcome the weight accorded him as an impartial medical specialist regarding whether appellant had residuals of his accepted

[10] *See Sharyn D. Bannick*, 54 ECAB 537 (2003).

[11] *See supra* note 5 (where an employee claims that, a condition not accepted or approved by OWCP was due to an employment injury, he bears the burden of proof to establish that the condition is causally related to the employment injury).

[12] *I.J.*, 59 ECAB 408 (2008).

right elbow strain and right biceps tendon rupture. OWCP therefore properly terminated appellant's wage-loss compensation and medical benefits on February 13, 2015.[13]

LEGAL PRECEDENT -- ISSUE 2

As OWCP met its burden of proof to terminate appellant's wage-loss compensation on February 13, 2015, the burden shifted to appellant to establish any disability causally related to the accepted right elbow strain and right biceps tendon rupture after February 13, 2015.[14] Causal relationship is a medical issue. The opinion of the physician must be based on a complete factual and medical background of the claimant, must be one of reasonable medical certainty and must be supported by medical rationale explaining the nature of the relationship between the diagnosed condition and the specific employment factors identified by the claimant.[15]

ANALYSIS -- ISSUE 2

The Board finds that appellant submitted insufficient medical evidence following the February 13, 2015 termination to establish disability after that day due to the February 15, 2011 employment injury, accepted for right elbow strain and right biceps tendon rupture.

After the February 13, 2015 termination, appellant submitted additional reports from Dr. Kalliny reports dated March 11 to October 30, 2015. Dr. Kalliny reiterated his opinion that appellant had CRPS due to the employment injury. On September 3, 2015 he advised that appellant could return to modified duty, and on October 2, 2015 reported that appellant had returned to work.

As noted, Dr. Kalliny had been on one side of the conflict in medical opinion evidence.[16] While he reiterated his opinion that appellant had CRPS due to the employment injury, this has not been accepted as employment related.

Appellant may submit new evidence or argument with a written request for reconsideration to OWCP within one year of this merit decision, pursuant to 5 U.S.C. § 8128(a) and 20 C.F.R. §§ 10.605 through 10.607.

CONCLUSION

The Board finds that OWCP met its burden of proof to terminate appellant's wage-loss compensation and medical benefits on February 13, 2015, and that he failed to establish continuing employment-related disability after that date due to the accepted right elbow strain and right biceps tendon rupture.

[13] *Manuel Gill*, 52 ECAB 282 (2001).

[14] *See Daniel F. O'Donnell, Jr.*, 54 ECAB 456 (2003).

[15] *Leslie C. Moore*, 52 ECAB 132 (2000); *Gary L. Fowler*, 45 ECAB 365 (1994).

[16] *See supra* note 12.

ORDER

IT IS HEREBY ORDERED THAT the November 13, 2015 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 21, 2017
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Patricia H. Fitzgerald, Deputy Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board